

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**

1. PLACE OF DEATH a. COUNTY		GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE		MARYLAND		b. COUNTY		GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		OAKLAND		c. LENGTH OF STAY IN 1b		9 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		OAKLAND		Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						GARRETT COUNTY MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day Year			
CLYDE		WILSON		BREEDLOVE				NOVEMBER		30		1966			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		FEBRUARY 9, 1890		77 yrs.		Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Carpenter				Building				Horse Shoe W. Va.				U.S.A.			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME									
ROBERT E. LEE BREEDLOVE						ALMA JANE SELL									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address			
No				220-03-7977				WIFE-PEARL M. BREEDLOVE-BOX # 118 RFD. # 1				OAKLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma of prostate DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 6 mos. 18 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			
								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan, 1966, to NOVEMBER 30, 1966, that (I) (we) last saw the deceased alive on NOVEMBER 30, 1966, and that death occurred at 7:40 AM, from the causes and on the date stated above.															
22a. SIGNATURE B. L. Grant								22b. DATE SIGNED 2 Dec 66							
22c. PHYSICIAN'S NAME (Type) DR. B. L. GRANT								22d. ADDRESS OAKLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
Burial				12/3/66				Texas Methodist Church Cemetery				Horse Shoe Run, W. Va.			
24. FUNERAL DIRECTOR John O. Durst Leighton-Durst Funeral Home, Oakland, Md.								25a. REC'D BY REGISTRAR Charles Judge DATE DEC 5 1966				25b. REGISTRAR'S SIGNATURE			

15081

15081

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>minutes</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett Co. Mem. Hospital</b>		e. STREET ADDRESS <b>10 E. Center St.</b>	
3. NAME OF DECEASED (Type or print) <b>Blanche Eva Colaw</b>		4. DATE OF DEATH <b>November 11, 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1882</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Natural Bridge, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter Burger</b>		14. MOTHER'S MAIDEN NAME <b>Regenia Sizer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Ernest Colaw, Sr.</b>		Address <b>see #2 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) <b>Diabetes mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b> M.D.		22. DATE SIGNED <b>11-11-66</b>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/14/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Oakland, Maryland</b>	
24. FUNERAL DIRECTOR <b>Charles N. Minnick</b>		25a. REC'D BY REGISTRAR <b>NOV 17 1966</b>	
ADDRESS <b>Oakland, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10085

10085



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT

15681

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15683

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Effie</u> First <u>Blanche</u> Middle <u>Detrick</u> Last				4. DATE OF DEATH <u>Nov.</u> <u>21</u> Day <u>19</u> Year <u>66</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1882</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Friendsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jonas Teats</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Slagle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Address <u>Miss Cora Detrick, Friendsville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>		EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>11-21-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/24/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Steele Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Friendsville, Garrett, Md.</u>	
24. FUNERAL DIRECTOR <u>Ruth E. Newman</u>				25a. REC'D BY REGISTRAR <u>Grantsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1000

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15682					15684				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				
GARRETT					MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN ID				
OAKLAND					26 DAYS				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
GARRETT COUNTY MEMORIAL HOSPITAL					BOX # 74				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last CHARLES WILLIAM FICKES, JR.					Month Day Year NOVEMBER 2 19 66				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		DECEMBER 12, 1927		38 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		
Attendant					Service Station		Pierce, W. VA.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
CHARLES WILLIAM FICKES, SR.					JUANITA LEWIS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Address		
yes WW 2					234-42-9400		W-IVA MAE FICKES-BOX 74, CRELLIN, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetes mellitus</i> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from <i>11/1/66</i> to <i>NOV. 2</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>NOV. 2</i> , 19 <i>66</i> , and that death occurred at <i>9:30 A.M.</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>B. L. Grant</i>								22b. DATE SIGNED <i>4 Nov 66</i>	
22c. PHYSICIAN'S NAME (Type) DR. B. L. GRANT								22d. ADDRESS OAKLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		11/4/66		George Cemetery		Garrett Co. Maryland			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<i>Donald D. Minnich</i> Oakland, Maryland						DATE NOV 9 1966		<i>Charles Judge</i>	

15084

15084

15084

15084

15084

15084

15084

15084

15084

15084

15084

15084

15084

15084

15084

15084

15084

15084

15084

15084



VR A15 (4)  
20 M 1/66

2.

## 15685

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>5 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Oak Rest Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DICIE</b> Middle <b>ELIZABETH</b> Last <b>FRIEND</b>		4. DATE OF DEATH Month <b>November 1,</b> Day <b>19</b> Year <b>66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1875</b>
9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	11. IF UNDER 24 HRS. Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Md. Sang Run, Garr. Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John F. Friend, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Rachael Ross</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>John F. Friend, Jr., McHenry, Md.</b>		Address (Brother)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>4221</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c) <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7-14-56</b> , 19 <b>66</b> , to <b>10-31-66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>10-31-66</b> , 19 <b>66</b> , and that death occurred at <b>4:30 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>James H. Feaster, Jr., M.D.</b>		22b. DATE SIGNED <b>Nov. 2, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>James H. Feaster, Jr., M.D.</b>		22d. ADDRESS <b>Oakland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/3/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Oakland, Maryland</b>
24. FUNERAL DIRECTOR <b>John O. Durst</b> <b>Leighton-Durst Funeral Home, Oakland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 7 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

15088

COMMITTEE OF CLERKS

15088

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

15684

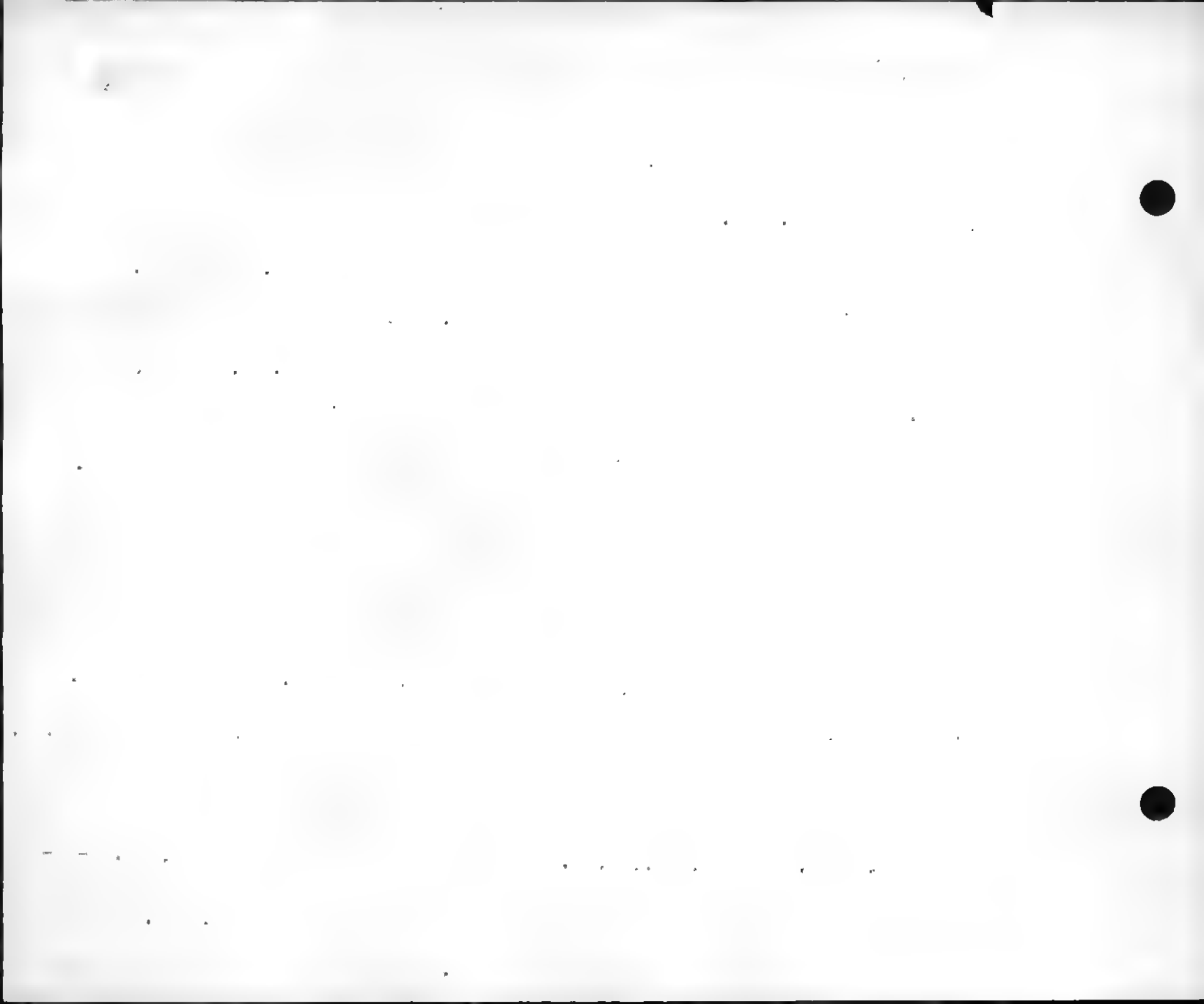
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15686

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Garrett</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, first tuition Residence before admission) a STATE <b>West Virginia</b> b COUNTY <b>Grant</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c LENGTH OF STAY IN 1b <b>Minutes</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>(DOA) Garrett Co. Mem. Hospital</b>		d STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <b>Harold Wayne Getz</b>		4 DATE OF DEATH <b>Nov. 19th. 1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 16, 1947</b>
9 AGE (in years last birthday) <b>19 yrs</b>		10 IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Shop</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Processing Plant</b>	
11 BIRTHPLACE (State or foreign country) <b>Petersburg, W. Va.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>F. Leon Getz</b>		14 MOTHER'S MAIDEN NAME <b>Irene Marie White</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. etc.) <b>No</b>		16 SOC. SEC. NO. <b>233-07-0334</b>	
17 INFORMANT <b>Nadine Idelman, Mt. Storm, W. Va.</b>		Address <b>(Sister)</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ASPHYXIATION</b> 8104 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ASPIRATION OF BLOOD</b> DUE TO (c) <b>FRACTURE OF MAXILLA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>n</b> <b>n</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Three car auto accident Rt. 500 2 mi. S. Loch Lynn, Md.</b>	
20c TIME OF INJURY Month, Day, Year <b>8:30 p.m. 11-19-66</b>		20d INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, street, office, etc.) <b>Highway</b>		20f (City or town) (County) (State) <b>(Rural) Mt. Lake Park Garr. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James H. Feaster, Jr., M.D.</b>		22. DATE SIGNED <b>Oakland, Md. 11-19-66</b>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11/22/66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Bayard Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Bayard, W. Va.</b>
24 FUNERAL DIRECTOR <b>John O. Durst</b>		25a REC'D BY REGISTRAR <b>John O. Durst</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>
Leighton-Durst Funeral Home, Oakland, Md.		DATE <b>NOV 23 1966</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

15685

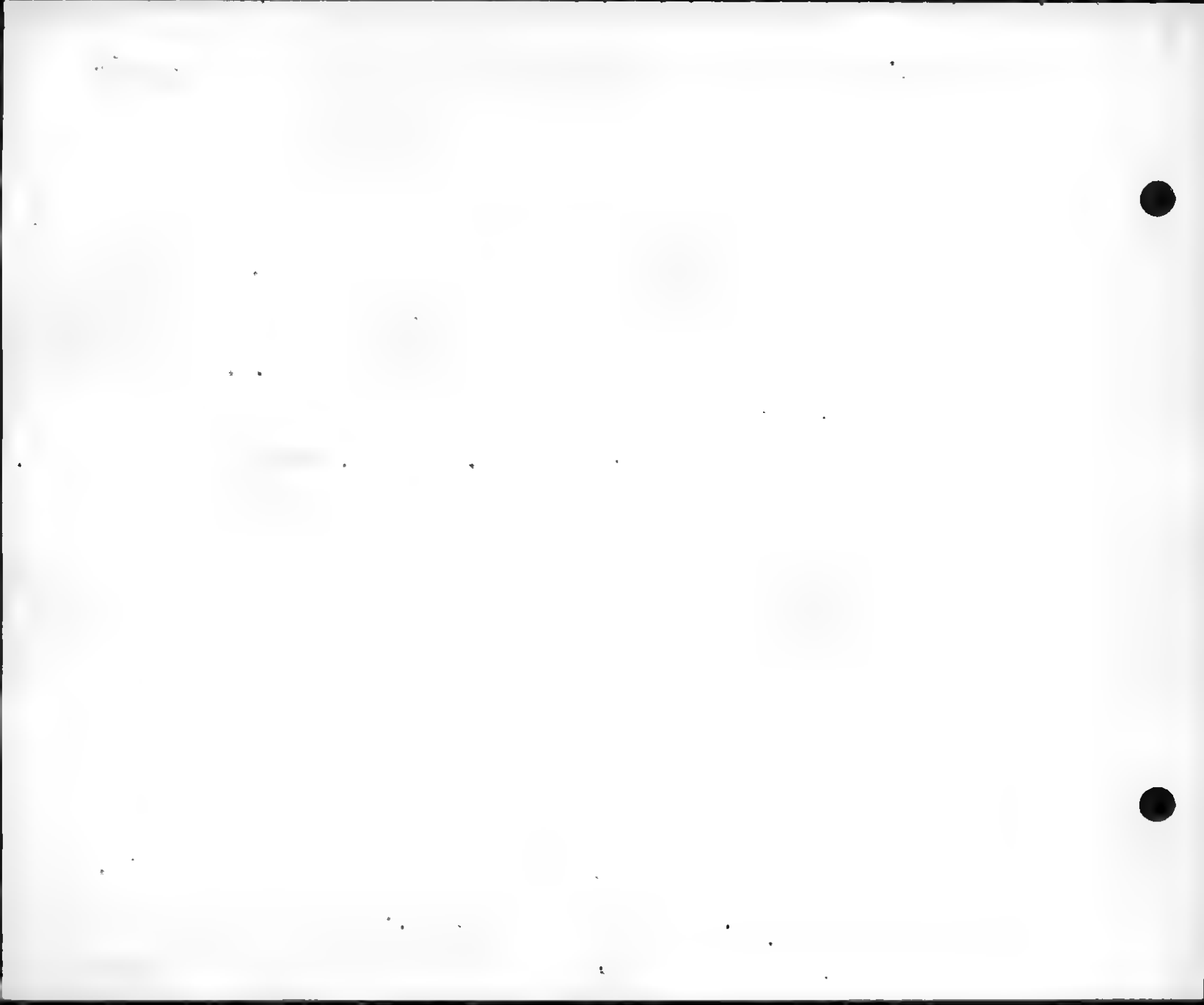
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15687

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Garrett</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrett</u>		c LENGTH OF STAY IN lb <u>3 hrs</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e STREET ADDRESS <u>6003 Pinchurst Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Gurney</u> Middle <u>James</u> Last <u>Godfrey</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 11, 1904</u>
9 AGE (In years last birthday) <u>62</u> yrs		10 UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	
11 BIRTHPLACE (State or foreign country) <u>Niagara Falls, N.Y.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>George Godfrey</u>		14 MOTHER'S MAIDEN NAME <u>Jean Kirby</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>212-07-4461</u>	
17 INFORMANT <u>Mrs. Ellen M. Godfrey, Baltimore, Md.</u>		Address (Widow)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1- Diabetes Mellitus 2- Previous myocardial infarct</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Oakland, Md.</u>	
22. DATE SIGNED <u>11-18-66</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/21/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Govan's Presby. Ch.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>John O. Durst</u> <u>Leighton-Durst Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>NOV 21 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15686

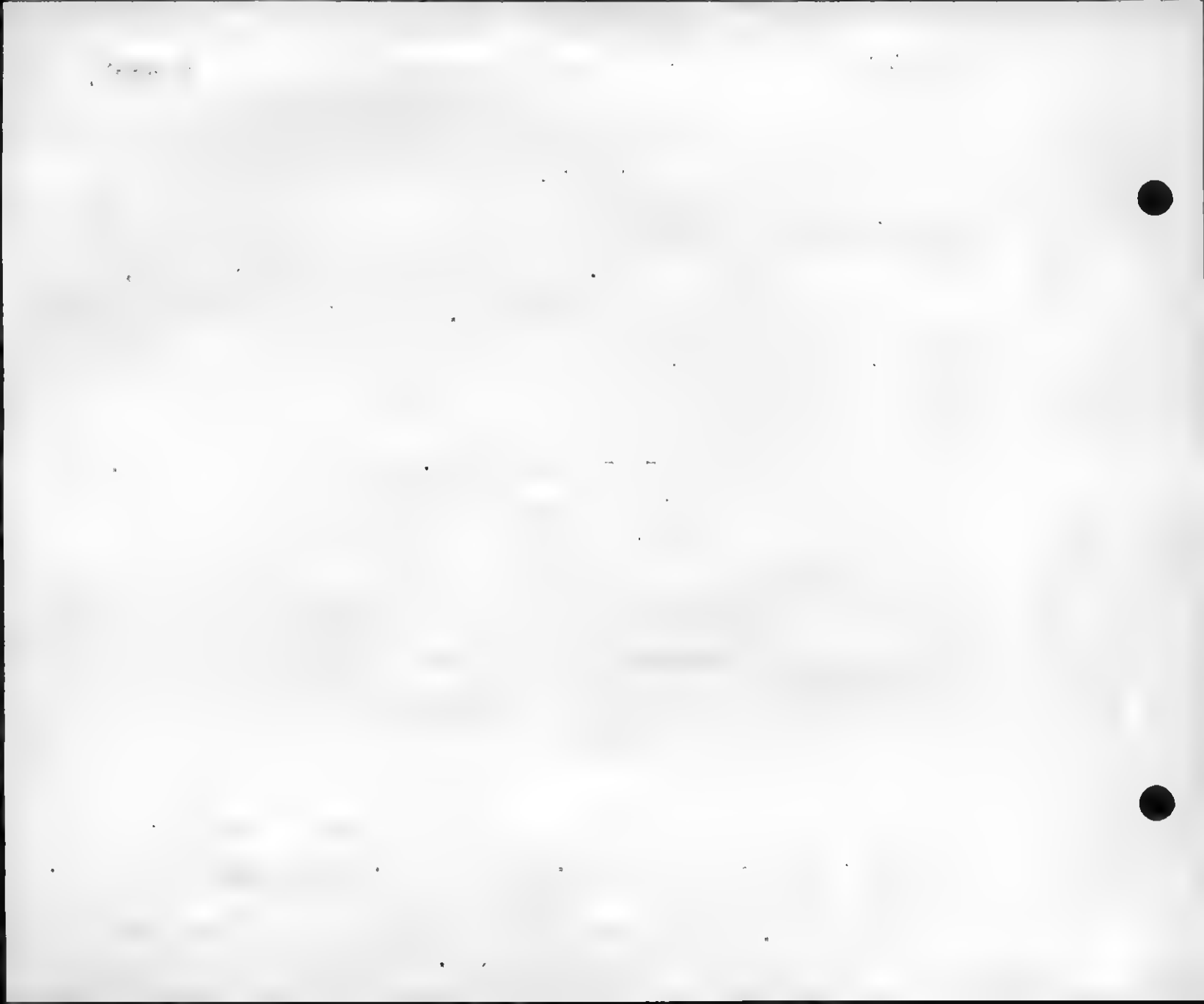
## CERTIFICATE OF DEATH

15688

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrett</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <b>Garrett-Weeks Nursing Home</b>		d. STREET ADDRESS <b>111</b>	
3. NAME OF DECEASED (Type or print) First <b>BETIE</b> Middle <b>L.</b> Last <b>HIPSEY</b>		4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 21, 1881</b>
9. AGE (In years last birthday) <b>85</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCC. PAT ON (Give kind of work done during most of working life, even if retired) <b>Professional Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Oakland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Conrad Michael</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Savage</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>217-20-1234</b>	
17. INFORMANT <b>Mrs. Leland Roth, Oakland, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b> 7-2-21 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3</b> Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1966</b> , <b>19</b> to <b>11-9-66</b> , <b>19</b> , that (I) (we) last saw the deceased alive on <b>11-8-66</b> , <b>19</b> , and that death occurred at <b>7:10 AM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>James H. Masterson, Jr., M.D.</b>		22b. DATE SIGNED <b>11-11-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>James H. Masterson, Jr., M.D.</b>		22d. ADDRESS <b>104 S. 2nd St., Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/13/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Oakland, Maryland</b>	
24. FUNERAL DIRECTOR <b>John C. Smith</b>		25. REC'D BY REGISTRAR <b>NOV 14 1966</b>	
26. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

15687

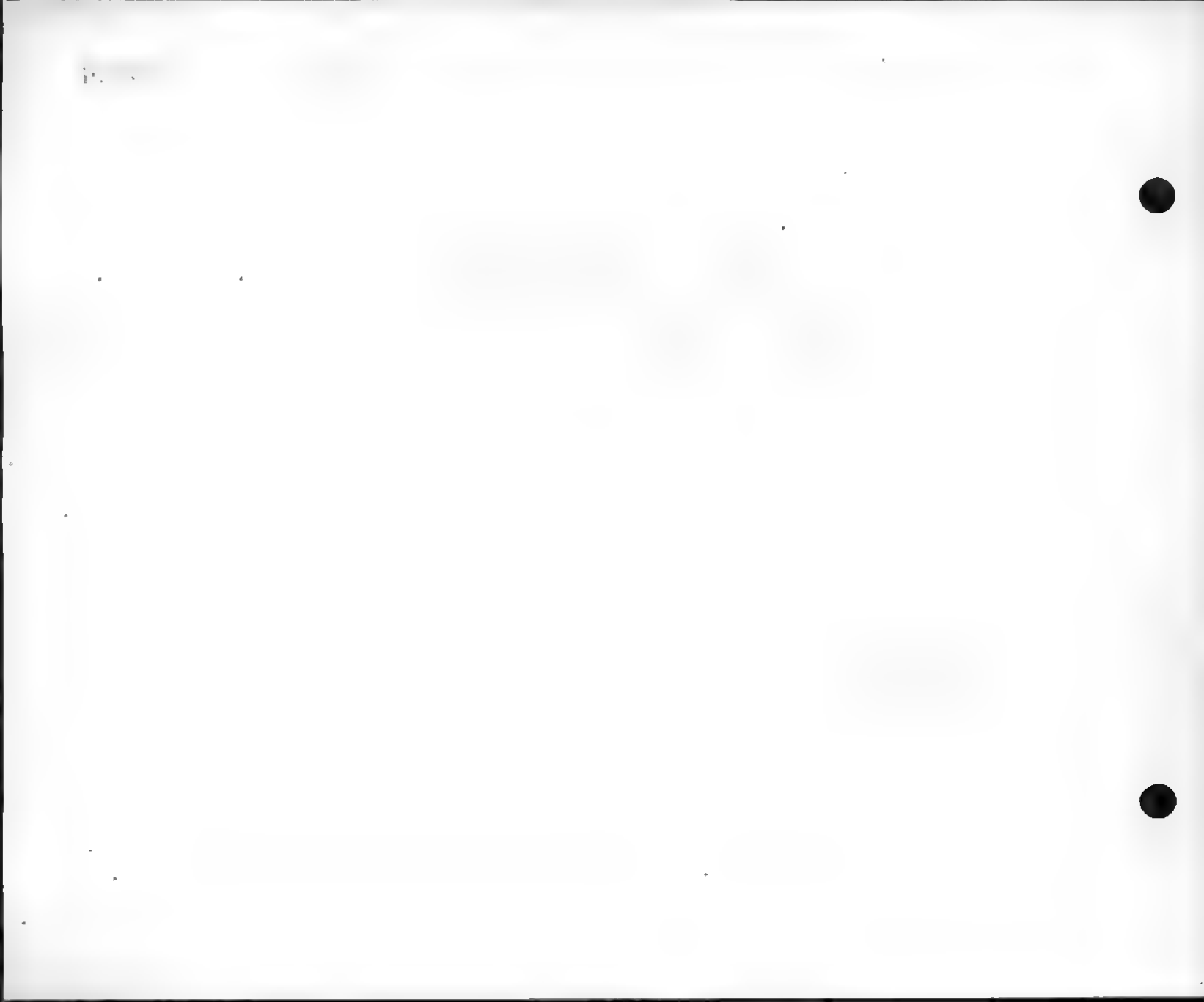
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15689

1 PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write R.R. and give nearest town) <b>Oakland</b>				c. LENGTH OF STAY IN 1b <b>Minutes</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>(DOA) Garrett Co. Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Cordelia Emeline Kissner</b>				4 DATE OF DEATH Month Day Year <b>Nov. 26th, 19 66</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Mar. 20, 1889</b>	9 AGE (In years last birthday) <b>77 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11 BIRTHPLACE (State or foreign country) <b>Saratoga Co., N. Y.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>
13 FATHER'S NAME <b>Gilbert Palmer</b>				14 MOTHER'S MAIDEN NAME <b>Julia Rockins</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>---</b>			16 SOCIAL SECURITY NO <b>---</b>		17 INFORMANT Address <b>Mrs. Barbara Kissner, Friendsville, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary thrombosis</b> DUE TO (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>Years</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral vascular accident May 1966</b>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22. DATE SIGNED <b>11-26-66</b> Address (Street, city, town, or county) <b>Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/27/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Steele Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Friendsville, Garrett, Md.</b>	
24 FUNERAL DIRECTOR <i>Ruth E. Newman</i> ADDRESS <b>Grantsville, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 30 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Carley Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

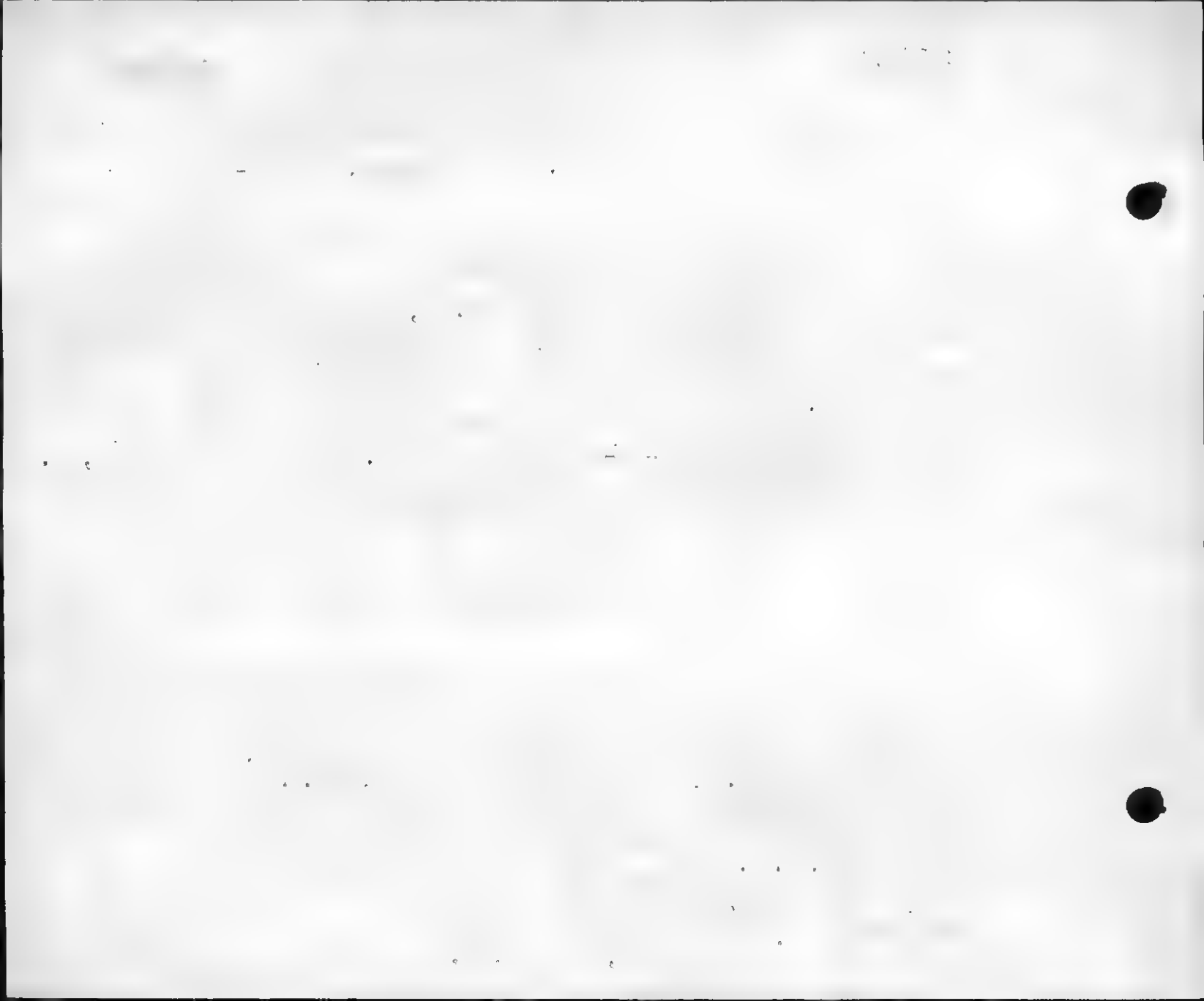
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15688

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

15690

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN lb <b>10 HRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND, Rural - Deer Park</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>HENRY</b> Last <b>LOHR</b>			4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>8</b> Year <b>1966</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 21, 1882</b>		9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Farming</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Garrett County MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>PETER J. LOHR</b>				14. MOTHER'S MAIDEN NAME <b>REBECCA WILBURN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-46-1850T</b>		17. INFORMANT <b>George W. Lohr, Friendsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>summoned of position</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b> <b>2 yrs.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 19 <b>66</b> , to <b>NOV. 8</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>NOV. 8</b> , 19 <b>66</b> , and that death occurred at <b>6:30 P.M.</b> on the causes and on the date stated above.							
22a. SIGNATURE <i>B. L. Grant</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov 6 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. B. L. GRANT</b>				22d. ADDRESS <b>OAKLAND, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/11/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Deer Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Deer Park, Maryland</b>	
24. FUNERAL DIRECTOR <b>John O. Durst</b> <b>Leighton-Durst Funeral Home, Oakland, Md.</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b> DATE <b>NOV 14 1966</b>			
				25b. REGISTRAR'S SIGNATURE			





**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

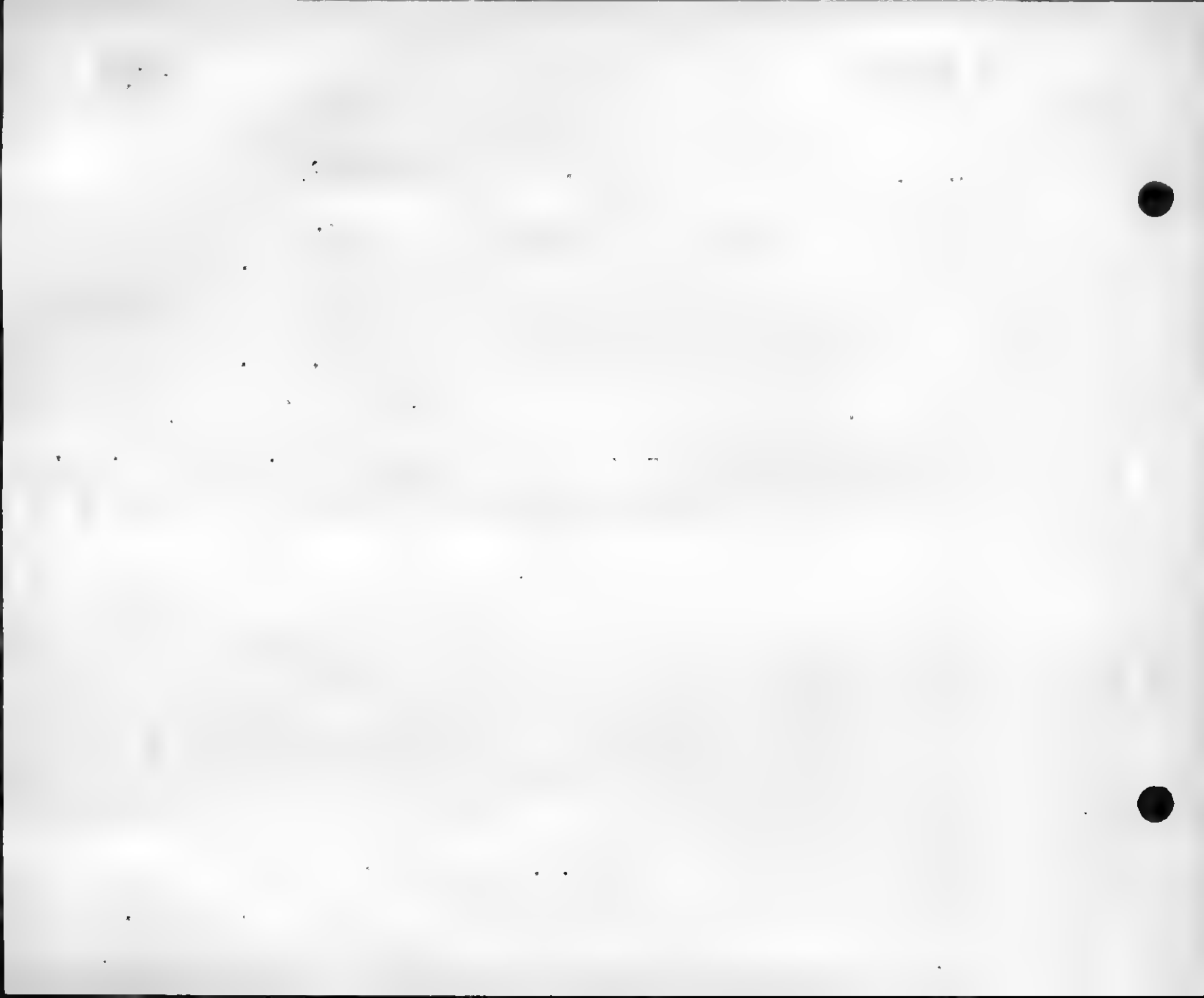
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15689

CERTIFICATE OF DEATH

15691

1. PLACE OF DEATH a. COUNTY <u>Garrett</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mountain Lake Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mountain Lake Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>600 "I" Street</u>		d. STREET ADDRESS <u>600 "I" St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Daisy Ray McHenry</u>		4. DATE OF DEATH Month Day Year <u>Nov. 10, 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1900</u>
9. AGE (in years last birthday) <u>66</u> yrs		IF UNDER 1 YEAR Months Days Hours Mins. <u>19 06</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>William F. Stottlemeyer</u>		14. MOTHER'S MAIDEN NAME <u>Matilda ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>220-40-1092</u>	
17. INFORMANT <u>James McHenry, Mt. Lake Park, Md.</u>		Address (Son)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ADVANCED DEGENERATIVE FAILURE</u> DUE TO <u>WITH GENERALIZED ANAEMIA</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>ARTERIO SCLEROTIC CARDIO VASCULAR</u> (c) <u>DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6mo</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 20</u> , 19 <u>66</u> , to <u>NOV 10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>NOV. 9</u> , 19 <u>66</u> , and that death occurred at <u>7:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>D. L. Baumgartner</u>		22b. DATE SIGNED <u>11/10/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. L. Baumgartner, M.D.</u>		22d. ADDRESS <u>Oakland, Maryland</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11/12/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Md.</u>
24. FUNERAL DIRECTOR <u>H. Wayne George Cumberland, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 14 1966</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15690

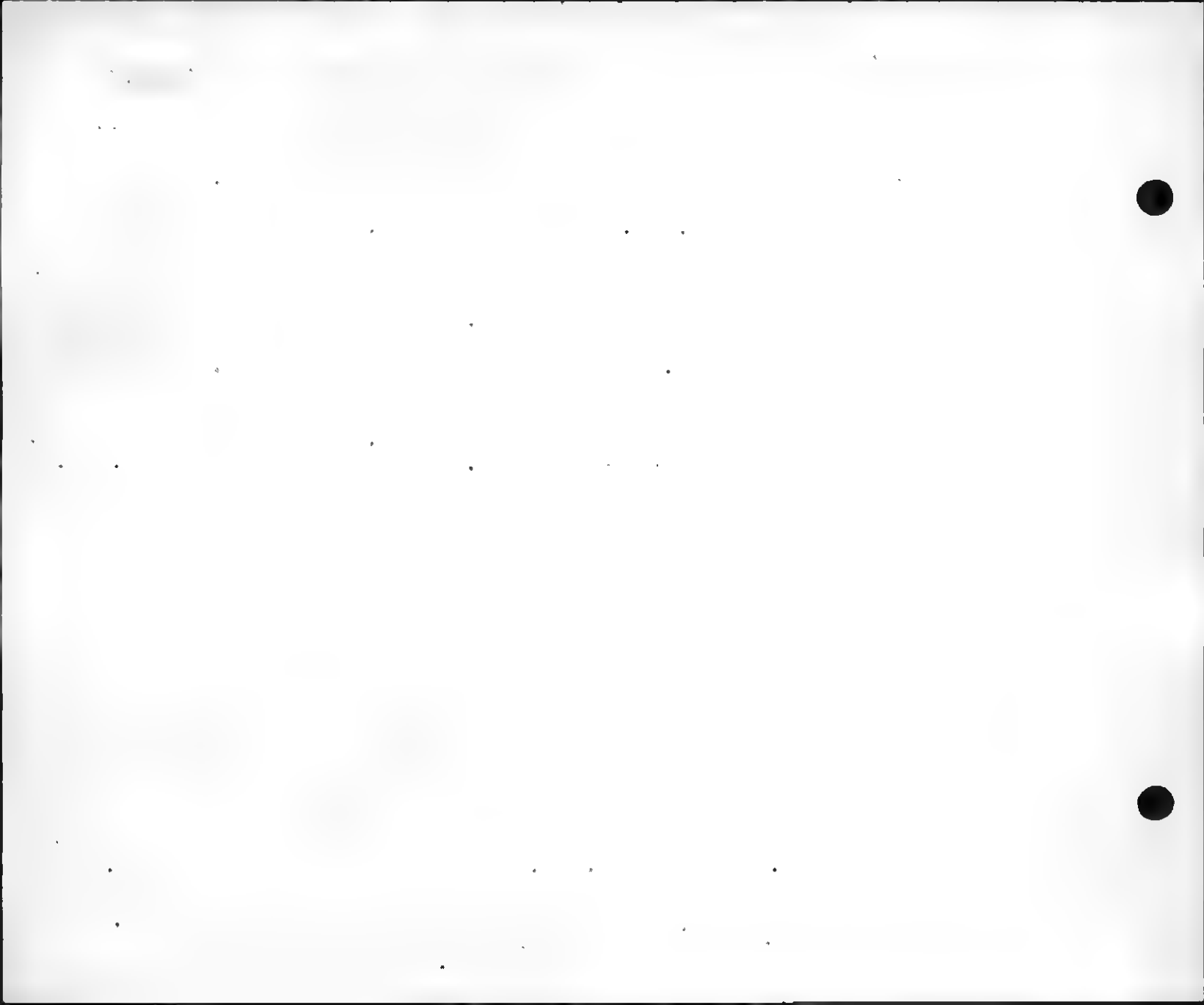
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15692

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Gorman, Maryland</u>				c. LENGTH OF STAY IN b <u>4 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route #1, Gorman, W. Va.</u>				d. STREET ADDRESS <u>Rural Rt. #1, Gorman, W. Va.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EARL WILLIAM MILLER</u>				4. DATE OF DEATH Month Day Year <u>November 11, 1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 9, 1885</u>	
9. AGE (in years last birthday) <u>81</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Liberty Furnace, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>235-16-7869</u>		17. INFORMANT (Den.) <u>Mrs. Claude Wilkins, Rt 1, W. Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>4211</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19__		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>J. H. Roaster, Jr., M.D.</u> EXAMINER'S NAME (Type)				22. DATE SIGNED <u>11-11-66</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Oakland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11/11/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Near Oakland, Md.</u>	
24. FUNERAL DIRECTOR <u>John O. Durst</u> <u>Lighter-Durst Funeral Home, Oakland, Md.</u>				25. DATED BY REGISTRAR <u>NOV 14 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

15691

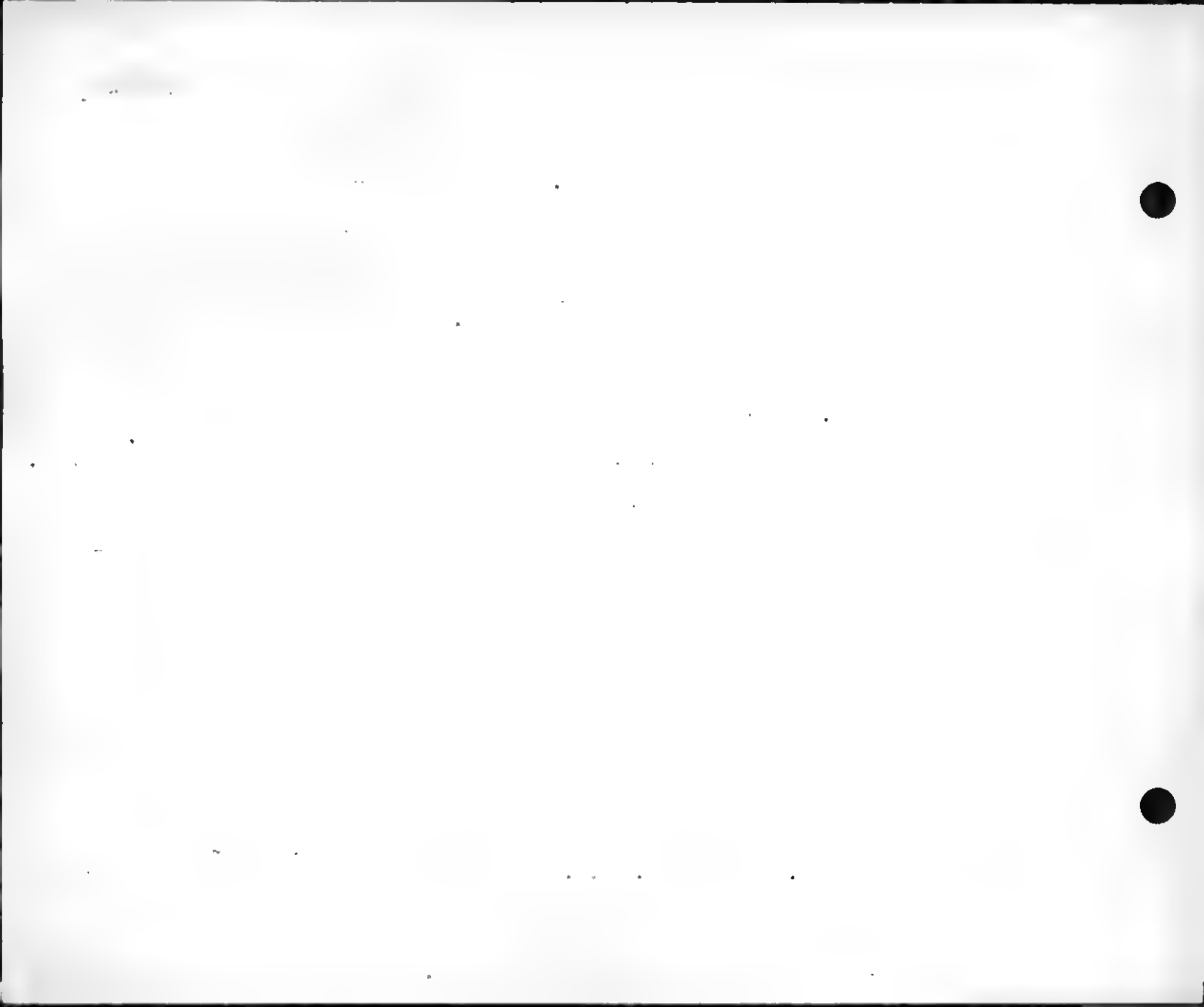
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15693

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>				c. LENGTH OF STAY IN b <b>18 Mo.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cupert-Weeks Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>WILLIAM HENRY MURPHY</b>				4 DATE OF DEATH <b>November 22, 1966</b>			
5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIAGE STATUS <b>WIDOWED</b>		8 DATE OF BIRTH <b>Jan. 24, 1890</b>	
9 AGE (in years, last birthday) <b>76</b>		10 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		11 BIRTHPLACE (State or foreign country) <b>Dunbar, Penna.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>George H. Murphy</b>				14. MOTHER'S MAIDEN NAME <b>Nettie Thomas</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16 SOCIAL SECURITY NO <b>213-01-56534</b>			
17 INFORMANT <b>Mrs. Arnold Bell, Rt 2, Oakland, Md.</b>				Address (Dom.)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 CORONARY THROMBOSIS, LEFT</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>CORONARY SCLEROSIS</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o m p m <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr. M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Oakland, Maryland</b>			
				Address (Street, city, town, or county) <b>11-30-66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)	
<b>Burial</b>		<b>12/3/66</b>		<b>Garrett Co. Memorial</b>		<b>Oakland, Maryland</b>	
24 FUNERAL DIRECTOR <b>O. Durst</b>				25a. REC'D BY REGISTRAR <b>John O. Lust</b>			
<b>Leighton-Durst Funeral Home, Oakland, Md.</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

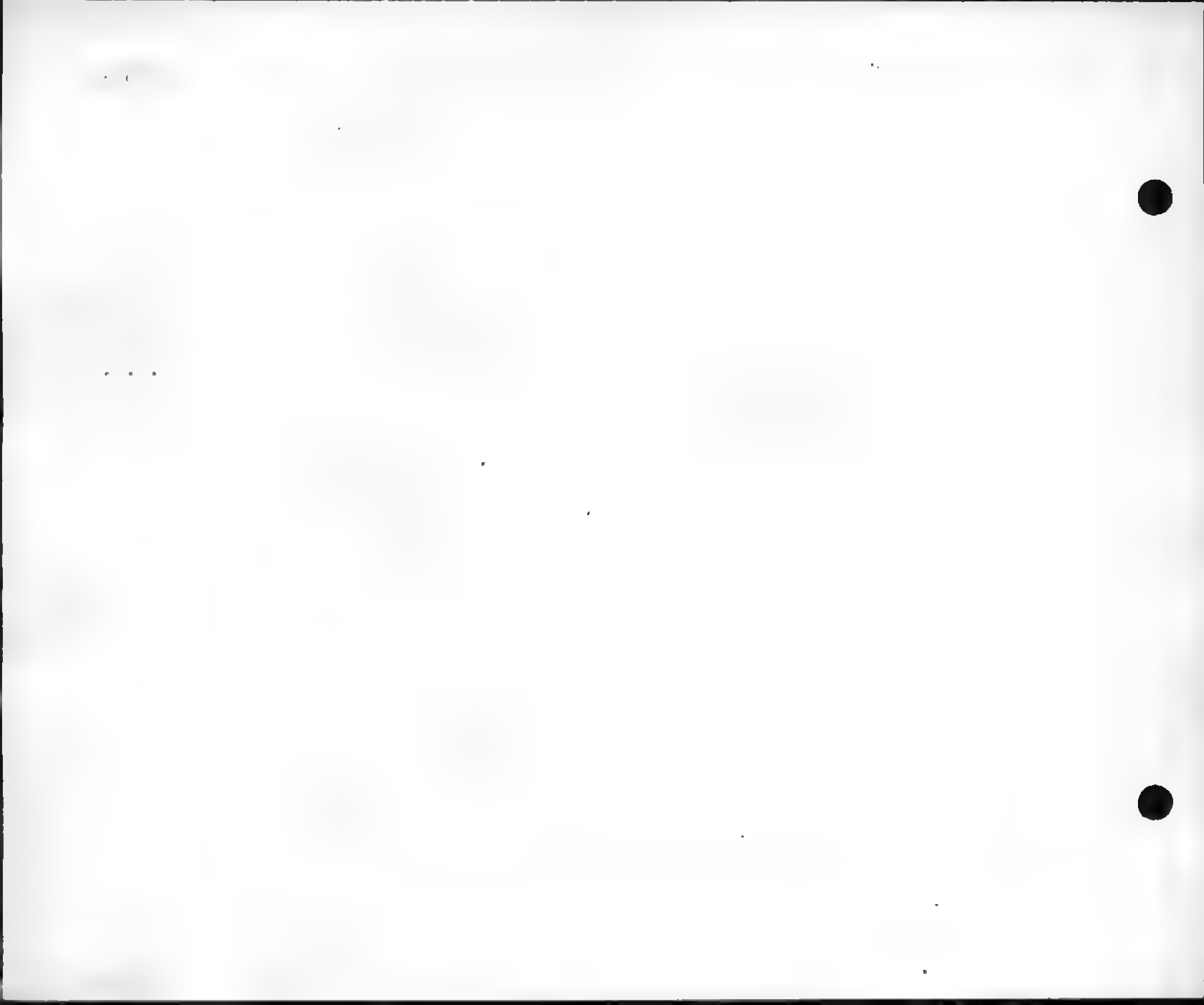
VR A15ME (5)  
6M 1/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15692

15694

1 PLACE OF DEATH a COUNTY <b>Garrett</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c LENGTH OF STAY IN TB <b>33 months</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cuppitt-Weeks Nursing Home</b>		d STREET ADDRESS <b>Calla Hill</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ida Belle Phares</b>		4 DATE OF DEATH Month Day Year <b>Nov. 13th. 19 66</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (in years last birthday) <b>85</b> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hilleary Brant</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Brotemarkle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>Mrs. DeNoma Yutzky</b>		Address <b>Calla Hill Mt Savage, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>4-2-1</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hr.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> M.D. EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		22. DATE SIGNED <b>11-13-66</b> Address (Street, city, town, or county) <b>Oakland, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11/16/66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Maryland</b>
24. FUNERAL DIRECTOR <b>H. Lee Silcox</b>		25a REC'D BY REGISTRAR <b>NOV 16 1966</b> 25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

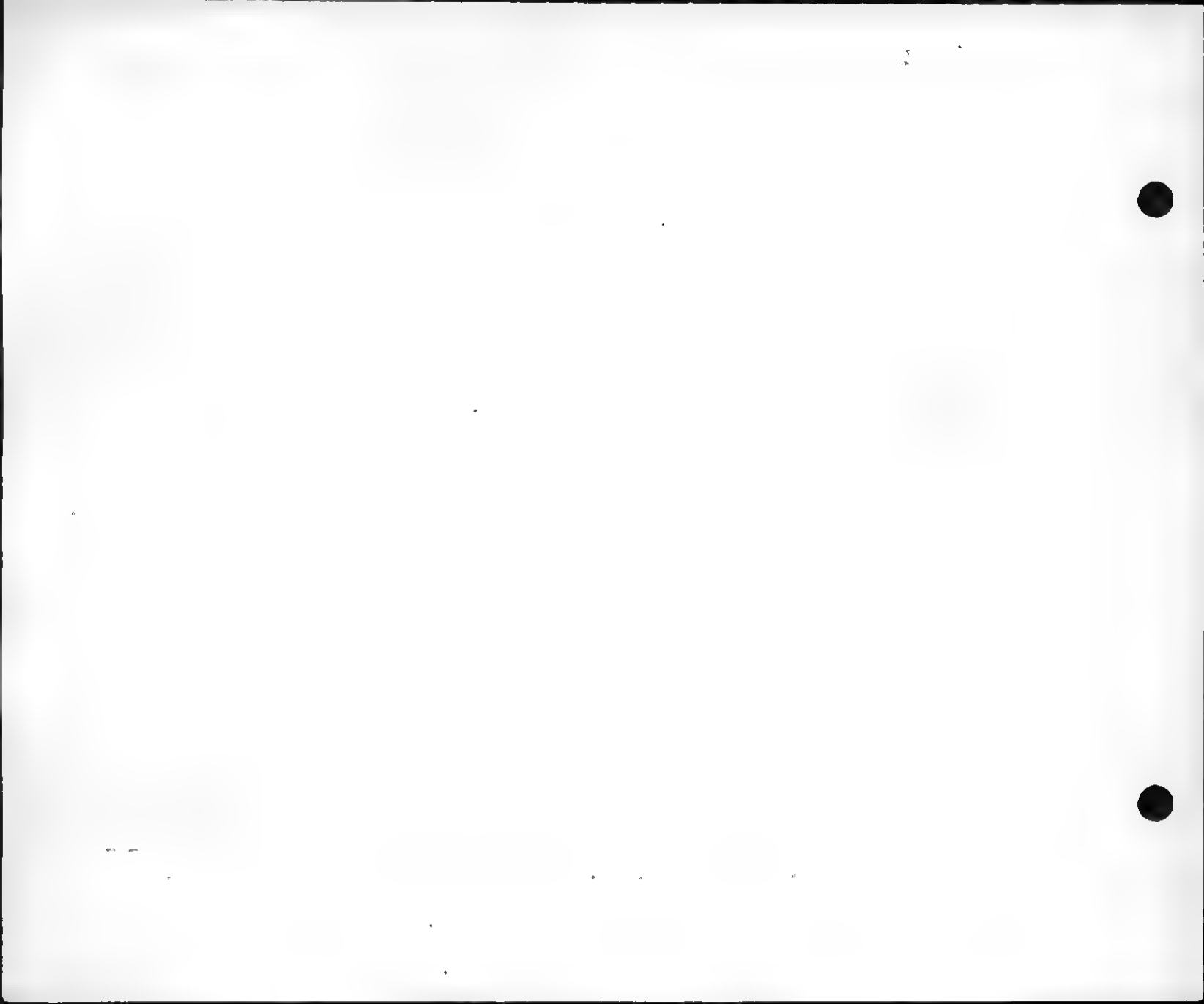
FOR STATE  
HEALTH DEPT

15693

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15695

1 PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Garrett</u>	
b CITY OR TOWN (If outside of corporate limits write RURAL and give nearest town) <u>Oakland</u>		c LENGTH OF STAY N 1b <u>1 Day</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Jacob Platter</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1982</u>	
5 SEX <u>W</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 7, 1882</u>
9 AGE (In years lost birthday) <u>34</u> yrs		10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
11 BIRTHPLACE (State or foreign country) <u>Jennings, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Henry Platter</u>		14 MOTHER'S MAIDEN NAME <u>Rachel Bittinger</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>Paul Wilt, R.D., Grantsville, Md.</u>	
18 CAUSE OF DEATH (Enter on any one cause per Part I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral vascular accident, left</u> DUE TO (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u>last.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>Years</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>11-14-66</u>	
ACTUAL SIGNATURE <u>James H. Feaster, Jr., M.D.</u> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Oakland, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11/7/66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Grantsville Cem.</u>	23d LOCATION (City or Town) (County) (State) <u>Grantsville, Garrett, Md.</u>
24 FUNERAL DIRECTOR <u>Ruth E. Newman</u>		25a REC'D BY REGISTRAR DATE <u>NOV 10 1966</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician and completed by the attending physician and completed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

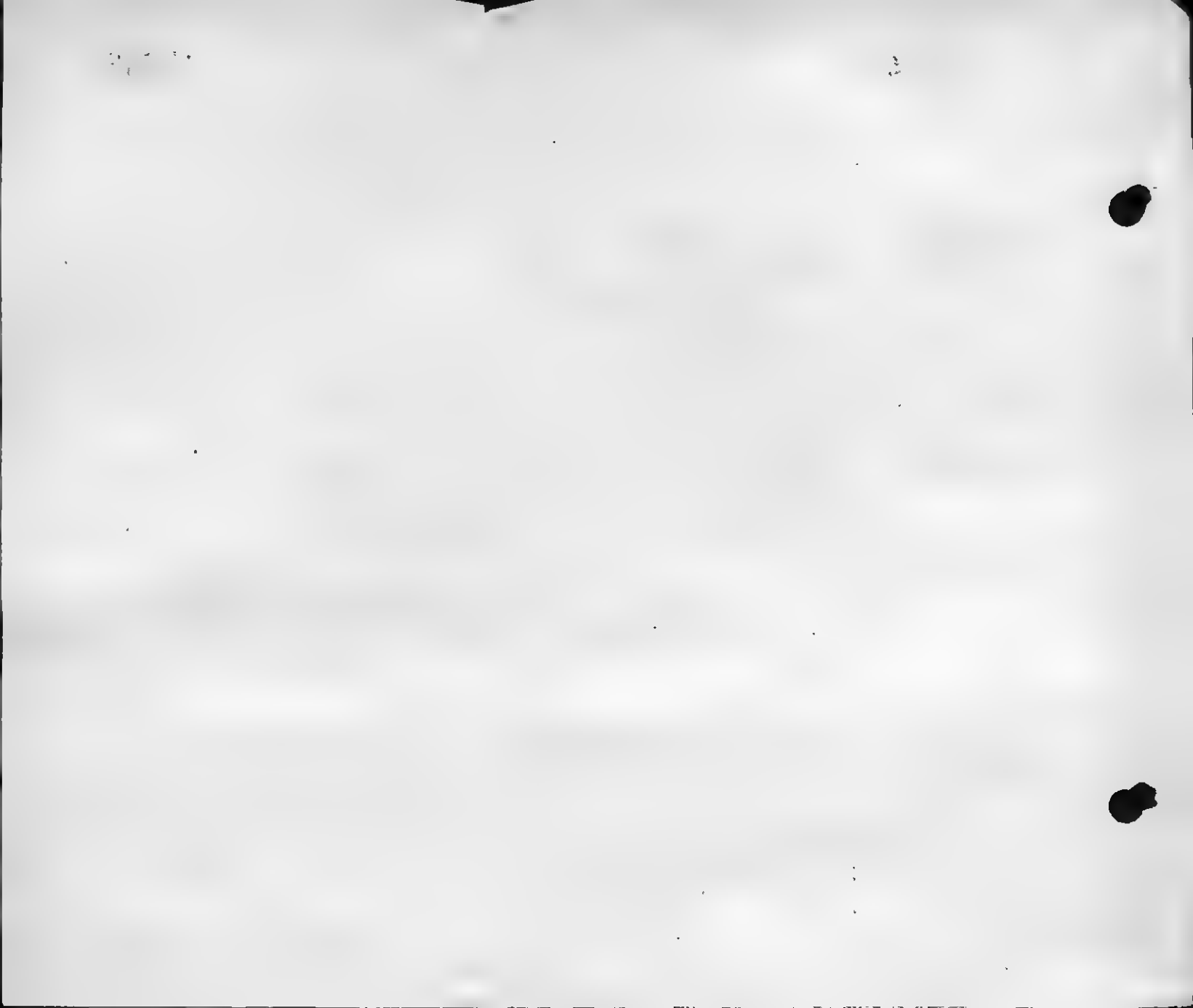
# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

15694

15696

1. PLACE OF DEATH a. COUNTY <u>Grant</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsburgh</u>	
c. LENGTH OF STAY IN 1b <u>10 Months</u>		d. STREET ADDRESS <u></u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u></u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MABLE ROSE RELYEA</u>		4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Saute Centre, Minn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John J. Buchanan</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Oliver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Rose M. Relyea, LeVelle, Pa.</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Cerebral Vascular Accident</u> (c) <u>Cerebral Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Arteriosclerotic Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> e.m. <u></u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>11/23</u> , 19 <u>66</u> to <u>11/26</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11/26</u> , 19 <u>66</u> , and that death occurred <u>2:15 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul E. Berkesile</u>		22b. DATE SIGNED <u>11/26/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL E. BERKESILE, M.D.</u>		22d. ADDRESS <u>349 MAIN ST. MEYERSDALE, PA.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/30/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Athens Rural Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Athens, Ga. Ga., U.S.A.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Judge</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 30 1966</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

15695

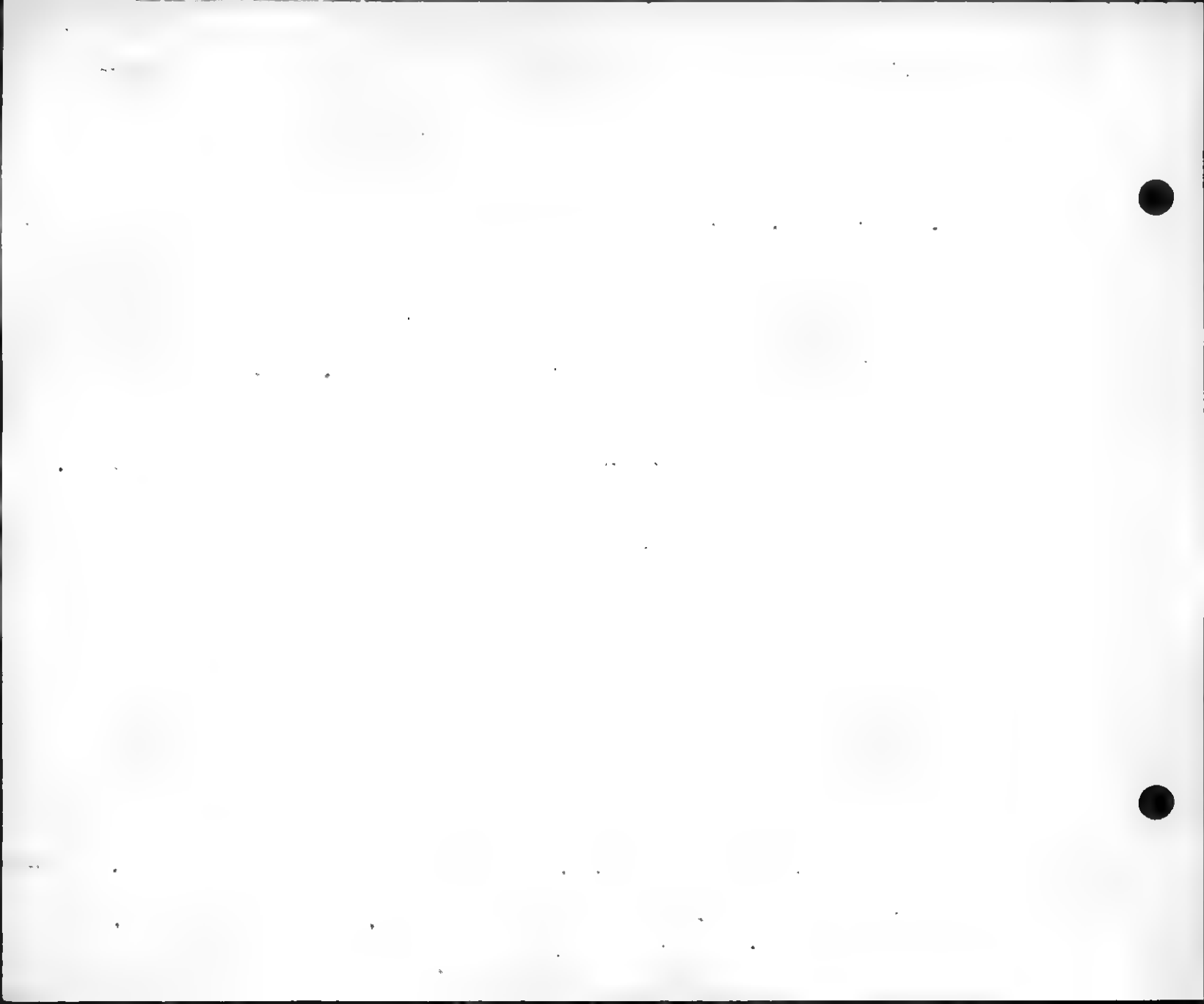
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15697

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY in 1d <b>Minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>(DOA) Garrett Co. Memorial Hospital</b>				d. STREET ADDRESS		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN ALBERT SAVAGE</b>				4. DATE OF DEATH <b>November 10, 1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1879</b>	9. AGE (In years last birthday) <b>87 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Soft Coal</b>		11. BIRTHPLACE (State or foreign country) <b>Garrett Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Savage</b>				14. MOTHER'S MAIDEN NAME <b>? Deitrick</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>220-10-2358</b>		17. INFORMANT <b>John E. Savage, Mt. Lake Park, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute</b> <b>42.1</b> DUE TO <b>Arteriosclerotic cardio-vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
21a. TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>		21b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		21d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James H. Feaster, Jr., M.D.</b> EXAMINER'S NAME (Type)				22. DATE SIGNED <b>Oakland, Md. 11-10-66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>11/13/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Oakland, Md.</b>	
24. FUNERAL DIRECTOR <b>John C. Durst</b> <b>Feighten-Durst Funeral Home, Oakland, Md.</b>				25. REC'D BY REGISTRAR <b>NOV 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT

15696

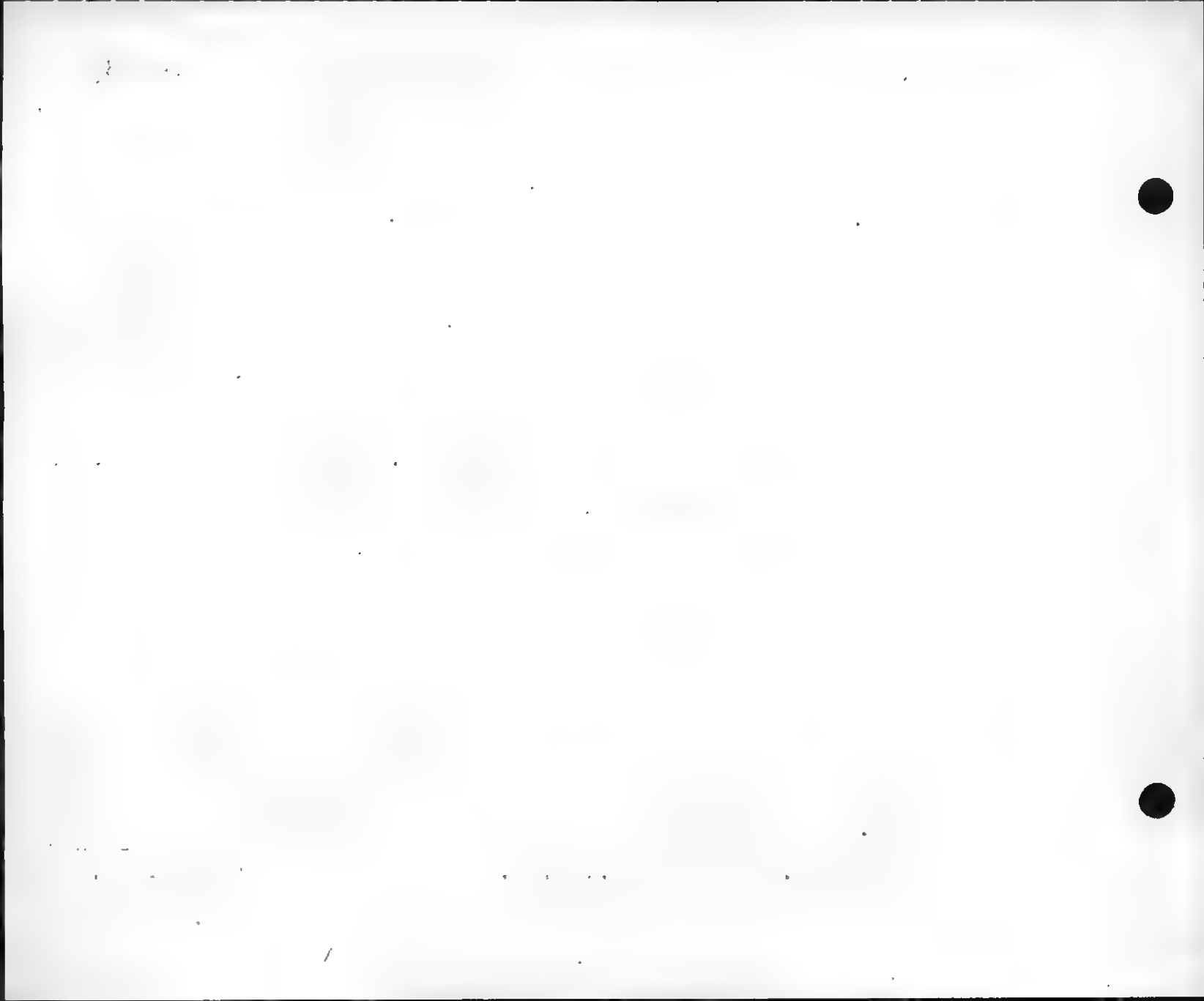
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15698

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate, writing the word "pending" in pen in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and it may be sent within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. 1</b>		e. STREET ADDRESS <b>Rt. 1</b>	
3. NAME OF DECEASED (Type or print) <b>John Carroll Skipper</b>		4. DATE DEATH Month <b>November</b> Day <b>24</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 20, 1881</b>
9. AGE (n years last birthday) <b>85</b>		10. F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Church</b>	
11. BIRTHPLACE (State or foreign country) <b>Swallow Falls, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Skipper</b>		14. MOTHER'S MAIDEN NAME <b>Romana Schaffer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>215-36-9823</b>	
17. INFORMANT <b>Clester B. Skipper</b>		Address <b>Oakland Rt. 2, Md</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Years</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> M.D.		22. DATE SIGNED <b>11-24-66</b>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city, town, or county) <b>Oakland, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/27/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Friend Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Garrett Co. Maryland</b>
24. FUNERAL DIRECTOR <i>Gerald N. Minnich</i> ADDRESS <b>Oakland, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 24 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



# CERTIFICATE OF DEATH

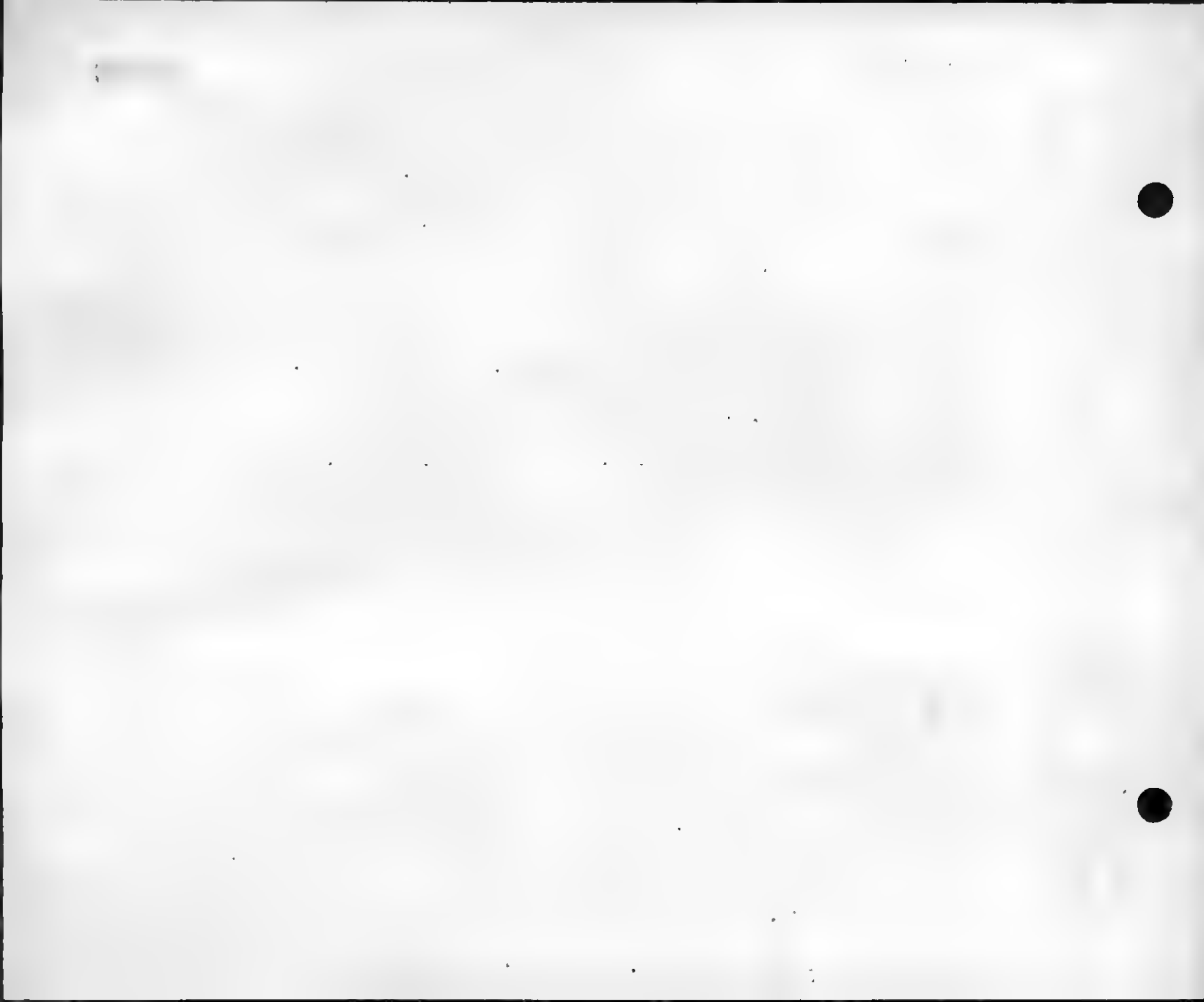
15697

15699

1 PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville</u>		c. LENGTH OF STAY IN 1b <u>One Year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Goodwill Mennonite Nursing Home</u>				d. STREET ADDRESS <u>155 Bedford Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Frances</u> Last <u>Smouse</u>				4 DATE OF DEATH Month <u>November</u> Day <u>2</u> Year <u>1966</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec 23, 1887</u>	9 AGE (in years last birthday) <u>78</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland Theater Co.</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Garrett Co. Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13 FATHER'S NAME <u>William P. Stanton</u>				14 MOTHER'S MAIDEN NAME <u>Annie Durst</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>214-05-8090</u>		17 INFORMANT <u>Thomas S. Smouse, Route 1, Eudrett, Pa</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive heart disease</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 11</u> , 19 <u>65</u> , to <u>Mar 2</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Mar. 1</u> , 19 <u>66</u> , and that death occurred at <u>  </u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>A. Paige Strong</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>11/2/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. PAIGE STRONG</u>				22d. ADDRESS <u>FROSTBURG, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 4, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grantsville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Grantsville, * Allegany Md</u>	
24 FUNERAL DIRECTOR <u>John J. Hafer</u>				25a. REC'D BY REGISTRAR <u>John J. Hafer</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
John J. Hafer, 238 Balto Ave. Cumberland, Md				DATE <u>NOV 7 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. It should be removed from the certificate and in any event, within 72 hours after death should be filed with the State Dept of Health prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15698

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

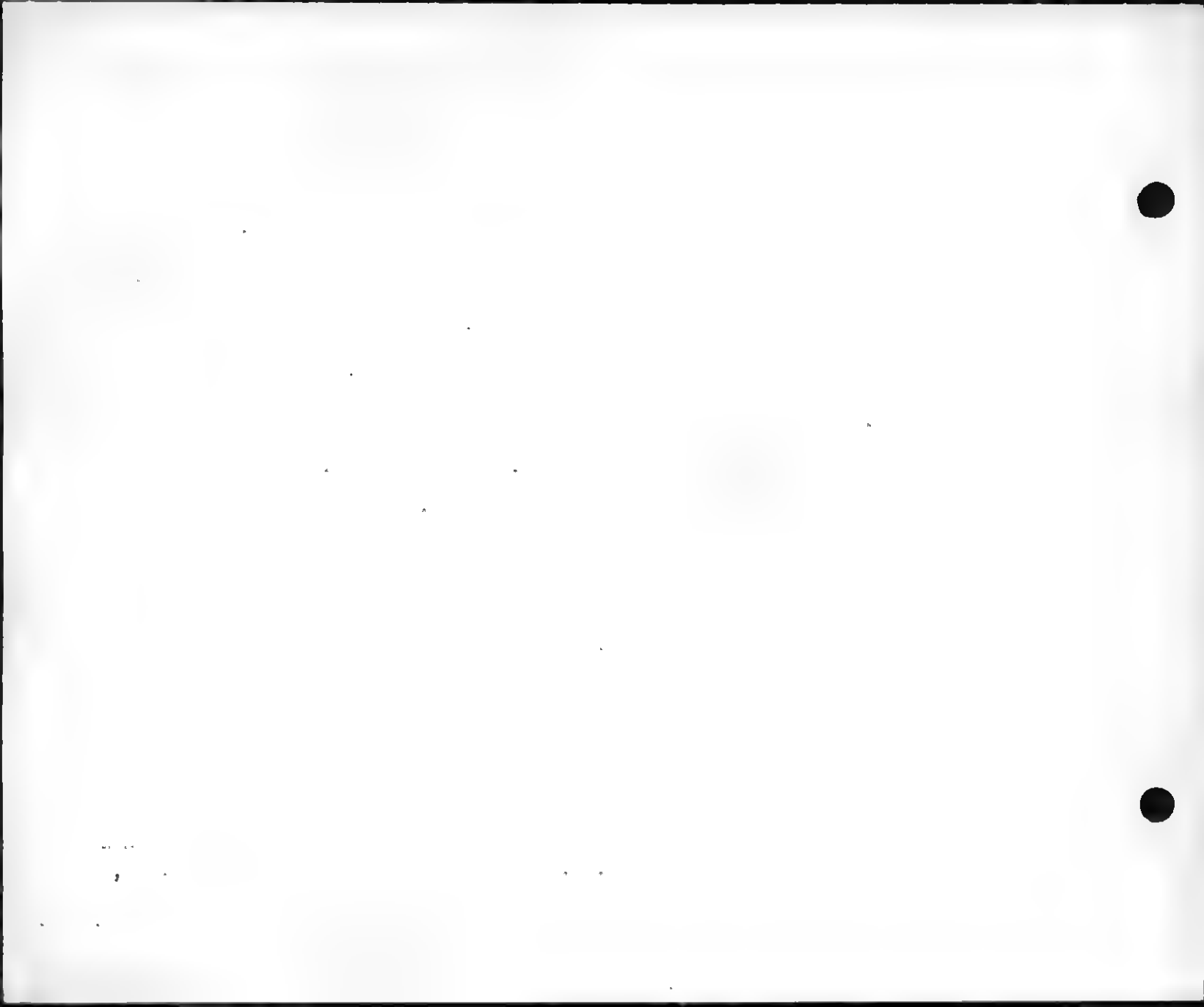
15700

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the ward pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b> c. LENGTH OF STAY IN 1b <b>Minutes</b>		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Raleigh</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beckley</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett Co. Mem. Hospital</b>		e. STREET ADDRESS <b>100 Stanley St.</b> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Russell</b> Middle <b>Edgar</b> Last <b>Weeks</b>		4 DATE OF DEATH <b>November 1st. 19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct. 31, 1913</b>
9 AGE (In years last birthday) <b>53</b>		10 UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal</b>	
11 BIRTHPLACE (State or foreign country) <b>Whittaker, W. Va.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>G. C. Weeks</b>		14. MOTHER'S MAIDEN NAME <b>Lou Ella Allen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>236-05-5204</b>	
17 INFORMANT <b>N. Branch Coal Co.</b>		Address <b>Bayard, W. Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion, left.</b> DUE TO (b) <b>Coronary sclerosis</b> DUE TO (c) <b>Myocardial infarction, old, right</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Myocardial infarction, old, right</b>			INTERVAL BETWEEN ONSET OF DEATH <b>Sudden</b> <b>Years</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James H. Feaster, Jr., M.D.</b>		22. DATE SIGNED <b>11-1-66</b>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/3/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Mem. Gardens</b>	23d. LOCATION (City or town) (County) (State) <b>Prosperity W. Va.</b>
24. FUNERAL DIRECTOR <b>Harold N. Minnich</b>		25a. REC'D BY REGISTRAR <b>NOV 9 1966</b>	
ADDRESS <b>Oakland, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

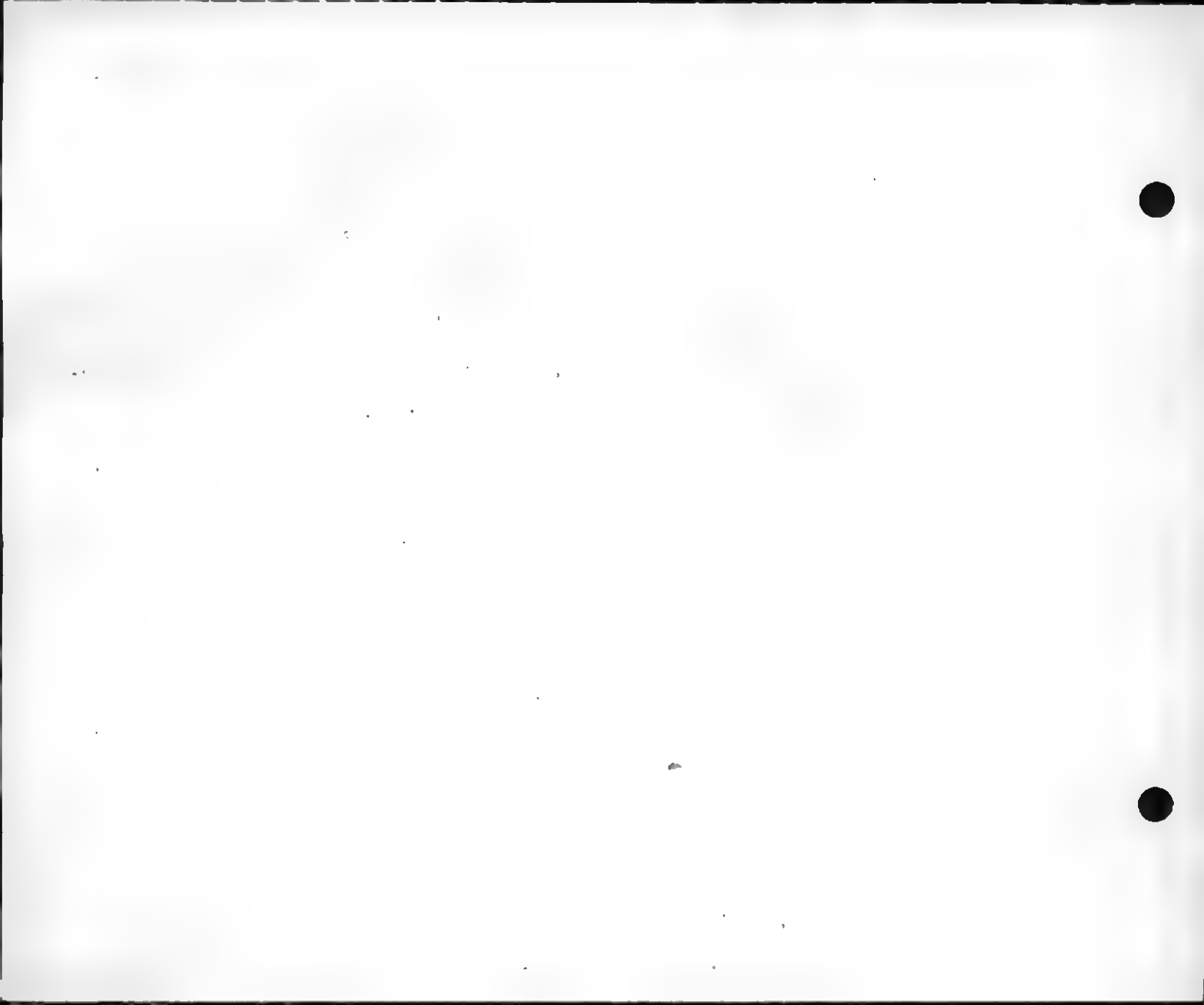
15699

15701

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROUTE 40, FROSTBURG</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES FRANKLIN WERNER</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 17, 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 16, 1941</b>
9. AGE (In years and birthday) <b>25</b> yrs		10. F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SPINNING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CELANESE CORP.</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MYLES WERNER</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH IACOVONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-40-3074</b>	
17. INFORMANT <b>MYLES WERNER, ROUTE 2, FROSTBURG, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ruptured Heart</b> 5164 DUE TO (Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last.) (b) <b>Crushed Chest</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>11</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Driver of Car in 2 car accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>2:00 a.m. 11-17 1966</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Route 5 Mi. West (Frostburg) Garrett, Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>JAMES FEASTER, M. D.</b>		22. DATE SIGNED <b>11-17-66</b>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>NOV. 21 '66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FINZEL CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>FINZEL, MD.</b>
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>		25a. RECEIVED BY REGISTRAR <b>NOV 21 1966</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15700

15702

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b> c. LENGTH OF STAY IN 1b <b>11 hrs. 35 mins</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett Co. Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Pylesville</b> d. STREET ADDRESS <b>Box 195 Onion Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Everett</b> Middle <b>Milton</b> Last <b>Winemiller</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>25th.</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-7-24</b>
9. AGE (In years last birthday) <b>42</b> yrs.		10. IF UNDER 1 YEAR Months <b>42</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Woodworker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture Factory York Co., Penna.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arch Winemiller</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Morris</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>178-22-9440</b>	
17. INFORMANT Address <b>(Widow)</b> <b>Mrs. Selma Winemiller, Pylesville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>CORONARY THROMBOSIS, LEFT</b> DUE TO (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) <b>---</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James H. Feaster, Jr., M.D.</b>		22. DATE SIGNED <b>Oakland, Md. 11-25-66</b>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Oakland, Md. 11-25-66</b> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/28/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fawn Grove Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Fawn Grove, Penna.</b>
24. FUNERAL DIRECTOR <b>John O. Durst</b> <b>Leighton-Durst Funeral Home, Oakland, Md.</b>		25a. REC'D BY REGISTRAR <b>John O. Durst</b> DATE <b>NOV 28 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

12708

12708

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15701						15703					
1. PLACE OF DEATH a. COUNTY						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE					
Garrett						Md.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
Grantsville						Grantsville					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS					
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
Barbara Y. Younkin						Nov. 28, 1966					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR: IF UNDER 24 HRS.	
F		W				Sept. 24, 1869		97 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
Housewife				Own Home		Grantsville, Md.				USA	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
John Yommer						Dorothy Hanft					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT				Address	
No				--		Mrs. Dorothy Glotfelty, Grantsville,				Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1958, 19 to Death, 19, that (I) (we) last saw the deceased alive on 11/23 1966, and that death occurred at 9A M, from the causes and on the date stated above.											
22a. SIGNATURE Harold O. Kamons M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov 30, 1966			
22c. PHYSICIAN'S NAME (Type) HAROLD O. KAMONS						22d. ADDRESS MARKLEYSBURG, PA.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
Burial		11/30/66		Grantsville Cemetery				Grantsville, Garrett, Md.			
24. FUNERAL DIRECTOR Don Newman						ADDRESS Grantsville, Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge	

1951

1951

25/11